HUMAN SERVICES

DIVISION OF MENTAL HEALTH SERVICES

Partial Care Services Standards

Proposed Readoption with Amendments: N.J.A.C. 10:37F

Authorized By: Kevin M. Ryan, Commissioner, Department of Human Services

Authority: N.J.S.A. 30:9A-10

Calendar Reference: See Summary below for explanation of exception to calendar requirement.

Proposal Number: PRN 2006-131

Submit written comments by July 14, 2006 to:

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The agency proposal follows:

Summary

Pursuant to N.J.S.A. 52:14B-5.1c, the Partial Care Services Standards, N.J.A.C. 10:37F, expire on November 17, 2006. The Department of Human Services (Department), through the Division of Mental Health Services (Division),

has reviewed these rules and has deemed them, along with the proposed amendments, to be necessary, reasonable and proper for the purpose for which they were originally promulgated. Therefore, the Department is proposing to readopt with amendments the Partial Care Services Standards.

The Department is providing a 60-day public comment period for this proposed readoption with amendments. Therefore, pursuant to N.J.A.C. 1:30-3.3(a)5, this proposal is not subject to the provisions of N.J.A.C. 1:30-3.1 and 3.2, governing rulemaking calendars.

The process of reviewing and updating these rules included extensive discussions with the Division of Medical Assistance and Health Services (DMAHS), with the goal of achieving consistency and coherence with the DMAHS rules concerning partial care services, N.J.A.C. 10:66A. In addition, the Division convened three public forums throughout the State to elicit the input of consumers, providers and other interested parties.

Over the last decade, a seismic shift in the philosophy and operation of mental health programs has occurred, fueled by a robust and articulate consumer movement. This shift refocused the thinking in the mental health field from a reliance on institution-based, deficit-focused, one-size-fits-all caretaking to a belief that consumers can be empowered to visualize, design, and achieve

their own state of wellness and recovery, with respectful and appropriate supports from community-based mental health programs.

State mental health agencies, charged with regulating community based programs, are incorporating these concepts into their policies and rules. (See the website for the National Association of State Mental Health Program Directors, NASMHPD, www.nasmhpd.org/spec_e-report_fall04intro.cfm).

In New Jersey, the concepts of wellness and recovery were embraced in a landmark initiative, the Governor's Task Force on Mental Health. While the Task Force undertook an examination of all aspects of the State's mental health system, a significant portion of the Task Force's Final Report (issued March 31, 2005, see http://www.nj.gov/mentalhealth/finalreport.html) emphasized the important concepts of wellness and recovery as foundational in the delivery of community-based mental health services (Task Force Report, pp. 80 - 104). The amendments proposed in this rulemaking action reflect wellness and recovery principles, as articulated in the Governor's Mental Health Task Force Report and Executive Order No. 78 (2006).

Based on an extensive review of the literature, the Task Force Report noted the hallmarks of a community mental health program rooted in wellness and recovery principles. Such a program is: (1) based upon best available evidence on effective treatments and rehabilitation; (2) easily accessible,

engaging all individuals in all phases of their illness and phases of recovery; (3) delivered in humane, respectful environments; (4) minimally dependent on coercive interventions and only when other options are exhausted; (5) flexibly designed to meet individual needs; (6) supportive of positive risks towards promotion of independence; (7) capable of providing a broad range of supports, including those from peers and through mutual self-help; (8) integrated in their approach to all the needs of the individual; and 9) conducive to fostering a sense of purpose in the lives of consumers (Task Force Report, p. 94).

In addition, staff must be "promoters of true, informed consumerism; optimistic and informed about recovery including working from a strengths focus, supportive towards positive risks taken by the consumer, respecting the importance of purpose and meaning in consumer's lives, promoting internal motivation; skilled in relevant interventions and best practices; trained and supervised in a relevant manner; respectful listeners and communicators; collaborators with consumer and families." (Task Force Report, p. 95, referencing the President's New Freedom Initiative (2003, 2004); and the National Association of State Mental Health Programs (NASMHPD) Technical Assistance Center e-Report on Recovery, www.nasmhpd.org/spec_e-report_fall04intro.cfm).

Recovery, the goal of community mental health programs, is the person-centered process of restoring or developing a positive and meaningful sense of

identity apart from one's condition and then rebuilding one's life despite, or within, the limitations imposed by that condition. (Thomas A. Kirk, Jr., Commissioner, Connecticut Department of Mental Health and Addiction Services). Some examples of recovery include: returning to a healthy state evidenced by improving one's mood and outlook on life following an episode of depression; managing one's illness such that the person can live independently and have meaningful employment and healthy social relationships; reducing the painful effects of trauma through a process of healing; attaining or restoring a desired state such as achieving sustained sobriety and building on personal strengths to offset the adverse effects of a disability. (Kirk)

Following is a summary of the subchapters in N.J.A.C. 10:37F.

Subchapter 1, General Provisions, states the scope and purpose of the rules and defines words and terms used in the chapter.

Subchapter 2, Partial Care Standards, delineates information regarding admission criteria, intake procedures, assessment, service planning, services to be provided, termination, transfer and referral of consumers, management functions, therapeutic environment, and staffing.

A summary of the proposed amendments follows.

Throughout the rules, “consumer” replaces “client,” to be consistent with current terminology, and “comprehensive service plan” is replaced with “individualized recovery plan” or “IRP.”

Subchapter 1. General Provisions

Proposed amendments at N.J.A.C. 10:37F-1.1(a) extend the rules’ applicability to all providers of partial care services, not just those receiving funds from the Division. This change is consistent with legislation requiring that any person conducting, maintaining, or operating a mental health program be licensed by the Department in accordance with rules adopted by the Department which prescribe standards for the provision of services by a mental health program (N.J.S.A. 30:9A-19).

Proposed amendments to N.J.A.C. 10:37F-1.1(b) restate the goal of partial care services in language that reflects greater respect for consumers’ self-determination and control over their own recovery. These amendments also clarify that partial care services must reflect a balance between recovery and clinical services. Partial care services take the form of individualized, comprehensive, non-residential, structured programming, which facilitate community integration, rather than becoming a permanent outcome itself. These services must be available on an hourly basis up to five hours per day, at least five days per week.

Proposed new N.J.A.C. 10:37F-1.2(a) delineates principles of wellness and recovery, which must guide the delivery of partial care services. New N.J.A.C. 10:37f-1.2(b) incorporates by reference the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM). The DSM contains the diagnostic criteria recognized and utilized by the mental health profession.

In the definitions section, several new terms have been added and a few have been amended or deleted. The existing definition for “Division” has been amended to update the current name of the Division. The definition for “partial care services” has been deleted and its terms have been added to a new definition, “partial care.” The definition for “provider agency” bears two amendments: (1) the phrase “has a contract with the Division to provide” has been deleted because, as stated above, all community mental health programs (not just those with a contract with the Division or the Department) must be licensed by the Department, have either a contract or affiliation agreement with the Department and be subject to its rules; and (2) language has been added to specify that partial care services are provided to adults with mental illness who meet the eligibility criteria set forth in this Chapter. The definition of “psychoeducation services” is proposed for deletion because proposed amendments more fully delineate this service (see proposed amendments to N.J.A.C. 10:37F-2.5(b)3).

New definitions for the following words and terms are proposed: active treatment; advanced practice nurse; certified psychiatric rehabilitation practitioner; clinician; community mental health associate; direct care staff; educational services; individualized recovery plan (IRP); interdisciplinary treatment team (IDTT), licensed professional counselor, licensed associate counselor, mental health services worker, off-site interventions, partial care, pre-vocational services, programs of assertive community treatment (PACT), qualified addictions staff, registered nurse, rehabilitation counselor, skill development, social worker, special minimum wage certificate, therapeutic subcontract work activity, therapeutic token economies, and vocational services.

Subchapter 2. Partial Care Standards

N.J.A.C. 10:37F-2.1 Admission criteria

Proposed amendments to N.J.A.C. 10:37F-2.1 separate the previously combined admission and intake criteria into two separate sections (N.J.A.C. 10:37F-2.1 and 2.2). Added language at N.J.A.C. 10:37F-2.1(a)1 clarifies that the provider agency shall utilize inclusionary and exclusionary criteria stated in the rule. Reference to consistency with the contract is being deleted because such criteria are not contained in the contract and because both contracted and non-contracted provider agencies are subject to this rule.

New N.J.A.C. 10:37F-2.1(b) delineates the specific inclusionary criteria to be used when evaluating an individual's eligibility for partial care services. These criteria are drawn from extensive discussions with the Division of Medical Assistance and Health Care Services to ensure consistency between N.J.A.C. 10:37F and future Medicaid reimbursement standards, which will affect Partial Care programs when they are formally promulgated.

New N.J.A.C. 10:37F-2.1(c) specifies criteria that will result in exclusion from partial care services.

N.J.A.C. 10:37F-2.2, Intake procedures

Existing N.J.A.C. 10:37F-2.1(b) and (c), dealing with the intake process have been recodified and reorganized into new N.J.A.C. 10:37F-2.2(a). Additional detail is proposed to clarify the existing requirement that a plan be formulated during the intake process. A proposed amendment specifies that this plan is called an "initial service plan". Another proposed amendment states that all intake procedures shall be guided by a consumer's preferences and goals with regard to treatment and community living. To ensure that services are provided in a manner that is meaningful and helpful to the individual, proposed N.J.A.C. 10:37F-2.2(a)1 requires that the initial contact orient and engage new consumers in a culturally and linguistically appropriate manner, and facilitate continuity of service. An additional provision at N.J.A.C. 10:37F-2.2(a)4 requires

that information listed at N.J.A.C. 10:37f-2.2(b) must be obtained during the face-to-face interview occurring during the intake process.

Several existing provisions are proposed to be recodified (or deleted and proposed as new in the proper location) as follows, without any substantive amendments:

Current	New
10:37F-2.1(b)	10:37F-2.2(a)
10:37F-2.1(c)	10:37F-2.2(a)2
10:37F-2.1(b)2	10:37F-2.2(a)3
10:37f-2.1(c)2	10:37F-2.2(a)4i
10:37F-2.1(b)3	10:37F-2.2(a)4ii
10:37F-2.1(c)9	10:37F-2.2(a)5
10:37F-2.1(c)4	10:37F-2.2(c)
10:37F-2.1(c)5	10:37F-2.2(d)

Additional amendments have been proposed at new N.J.A.C. 10:37F-2.2(b) (recodified from N.J.A.C. 10:37F-2.1(c)3) which state the reason for the requirement that written policies and procedures be developed regarding documentation of intake interviews. The proposed amendment specifies the purpose of this requirement is to ensure an adequate basis for a timely and accurate consumer assessment.

At new N.J.A.C. 10:37F-2.2(b)1 (recodified from N.J.A.C. 10:37F-2.1(c)3i), a proposed amendment specifies that the required obtained is demographic in nature. At new N.J.A.C. 10:37F-2.2(b)2 (recodified from N.J.A.C 10:37F-2.1(c)ii), proposed amendments add that problems and reasons for referral may include consumer interests and preferences in achieving valued community living, learning, working or social roles. At N.J.A.C. 10:37F-2.2(b)3 (recodified from N.J.A.C. 10:37F-2.1(c)3iii, iv, & v), proposed amendments specify that a medical history shall be documented, including a consumer self-report of response to previous treatment, a completed current mental status evaluation, medical information, current mental health and social service providers and any allergies. At new N.J.A.C. 10:37F-2.2(b) (recodified from N.J.A.C. 10:37F-2.1(c)3vi), a signed authorized (changed from "consent") is required, consistent with HIPAA. At new N.J.A.C. 10:37F-2.2(b) (recodified from N.J.A.C. 10:37F-2.1(c)3x), the phrase "basic chemical dependency" is replaced with "basic substance dependency," consistent with current usage. At new N.J.A.C. 10:37F-2.2(b)8, basic employment and educational history is added. At new N.J.A.C. 10:37F-2.2(b)9 (recodified from N.J.A.C. 10:37F-2.1(c)3xi), the risk of sexually predatory behavior is added to the list of risk factors that must be documented.

A proposed amendment at N.J.A.C. 10:37F-2.2(e)1, 2, and 3 (recodified from N.J.A.C. 10:37f-2.1(c)6, 7 and 8) clarifies that the initial service plan shall address the consumer's "immediate needs and concerns," not just the "need and

concerns," and shall be revised as necessary until the individualized recovery plan is developed within six weeks of intake.

N.J.A.C. 10:37F-2.3, Assessment planning

Proposed amendments divide existing N.J.A.C. 10:37F-2.2, Assessment and service planning, into two sections – N.J.A.C. 10:37F-2.3, Assessment, and N.J.A.C. 10:37F-2.4, Recovery planning.

At new N.J.A.C. 10:37F-2.3(a) (recodified from N.J.A.C. 10:37F-2.2), proposed amendments require that the PA complete a written comprehensive assessment for each consumer prior to the development of the Individualized Recovery Plan, which will provide an initial profile of the strengths and barriers related to community integration, achievement of chosen valued roles and which issues or problems must be addressed in what priority.

At new N.J.A.C. 10:37F-2.3(a)1 (recodified from N.J.A.C. 10:37F-2.2(a)1), proposed amendments require that every comprehensive assessment include the consumer's skill and resource strengths and barriers to attainment of the consumer's self-expressed goals related to community integration and living, learning, working and social role recovery in several designated areas. At new N.J.A.C. 10:37F-2.3(a)1i (recodified from N.J.A.C. 10:37F-2.2(a)1i), proposed amendments require that the consumer's interest in and strengths and goals

related to participation in the program be considered (replacing “motivation, including willingness to participate”). At new N.J.A.C. 10:37F-2.3(a)1ii (recodified from N.J.A.C. 10:37F-2.2(a)1ii), a proposed amendment replaces “recreational” with “leisure”, as an area which should be considered in the comprehensive assessment. At new N.J.A.C. 10:37F-2.3(a)1iii (recodified from N.J.A.C. 10:37F-2.3(a)1iii), proposed amendments add “trauma” to the emotional and psychological characteristics that must be considered in the comprehensive assessment. At N.J.A.C. 10:37F-2.3(a)1iv (recodified from N.J.A.C. 10:37F-2.2(a)1iv), proposed amendments replace “physical health” with the more comprehensive “a review of medical systems” and also specify that this review shall include “screening for current physical, emotional, sexual abuse and/or neglect.”

An amendment at N.J.A.C. 10:37F-2.3(a)2 (recodified from N.J.A.C. 10:37F-2.2(a)) provides more specific direction to providers by stating that the written comprehensive assessment shall “clearly indicate” (rather than “include sufficient”) justification for the need for PC services.

New N.J.A.C. 10:37F-2.3(a)4 requires the written comprehensive assessment to describe both the skills and resources needed to attain the consumer’s expressed goals and valued roles, including the quality of life, based

upon, but not limited to, consumer interviews, direct observation and information obtained from family members and other collaterals.

A proposed amendment recodifies N.J.A.C. 10:37F-2.2(a)3 as N.J.A.C. 10:37F-2.3(a)5 and changes the deadline for completion of the written comprehensive assessment from three months to one month after acceptance to the program and prior to the development of the individualized recovery plan (IRP).

Another proposed amendment recodifies N.J.A.C. 10:37F-2.2(a)4 as N.J.A.C. 10:37F-2.3(a)6 and changes the deadline for completion of the documented psychiatric evaluation from within four weeks of admission to within two weeks. Proposed amendments add a new factor to be considered in the psychiatric evaluation - the consumer's expressed interests, preferences, strengths and goal(s) related to valued community roles and quality of life. A proposed amendment at N.J.A.C. 10:37f-2.3(a)6i adds Axis IV and V to the list of diagnoses that must he considered from the Diagnostic and Statistical Manual of Mental Disorders IV.

Recognizing potential difficulties in involving third parties in the program, a proposed amendment to N.J.A.C. 10:37F-2.3(a)7 (recodified from N.J.A.C. 10:37F-2.3(a)5) requires the PA to "make reasonable efforts to" involve family and significant others in the assessment process to the extent possible.

New N.J.A.C. 10:37F-2.3(a)8 is proposed to require the PA to conduct continued functional and resource assessments of those areas, goals, and objectives prioritized from the comprehensive assessment and selected for formulation in the individualized recovery plan. These ongoing assessments must be completed prior to the three-month review of the IRP and documented in the clinical record.

N.J.A.C. 10:37F-2.4 Recovery planning

At new N.J.A.C. 10:37F-2.4(a) (recodified from N.J.A.C. 10:37F-2.2(b)), proposed amendments delineate the requirements for the Individualized Recovery Plan (IRP). A proposed amendment at new N.J.A.C. 10:37F-2.4(a) (recodified from N.J.A.C. 10:37F-2.2(b)1) states that the IRP is designed to assist the consumer in organizing, reviewing and modifying an array of treatment and rehabilitation services which supports his or her identified path to recovery, rather than just being based on the comprehensive assessment. The proposed amendment also requires that the IRP be based on specific areas of interest identified by the consumer and urgent problems or barriers which have been prioritized from the comprehensive assessment. At new N.J.A.C. 10:37F-2.4(a)1 (recodified from 10:37F-2.2(b), proposed amendments require that the IRP be formulated and implemented at the completion of the comprehensive assessment, but no later than six weeks (changed from three months) from the consumer's admission to the program. At new N.J.A.C. 10:37F-2.4(a)2

(recodified from N.J.A.C. 10:37F-2.2(b)), proposed amendments add a new sentence, stating that areas identified in the comprehensive assessment but not initially addressed in the IRP should be reviewed and formulated at subsequent IRP reviews or when re-prioritized by the consumer and the PA.

At new N.J.A.C. 10:37F-2.4(b) (recodified from N.J.A.C. 10:37F-2.2(b)1), an amendment is added requiring that the IRP be developed with the consumer. At new N.J.A.C. 10:37F-2.4(b)3 (recodified from N.J.A.C. 10:37F-2.2(b)1iii), a proposed amendment adds that an advance practice nurse (as well as a psychiatrist) may sign the IRP to reflect the course of treatment. New N.J.A.C. 10:37F-2.4(b)4 a proposed amendment adds greater detail regarding the nature of family involvement in developing the IRP. At 10:37F-2.4(b)5 (recodified from N.J.A.C. 10:37F-2.2(b)1v), proposed amendments specify that the goals stated in the IRP must be the consumer's own self-stated goals relate to chosen, valued roles and must include specific plans to achieve these roles and further in-depth and ongoing assessment in the identified areas, rather than just "client goals and objectives." At new N.J.A.C. 10:37F-2.4(b)6 (recodified from N.J.A.C. 10:37F-2.2(b)1vi and vii), proposed amendments add greater detail regarding the nature of partial care services and activities to be provided, including that these activities and interventions must be designed to implement the IRP and must include clear reference to necessary off-site services to assist in the transfer of learning. New N.J.A.C. 10:37F-2.4(b)8 requires that the IRP include a comment section under

which the consumer may state any concerns, agreements or disagreements with either the development of or the final IRP.

At N.J.A.C. 10:37F-2.4(c) (recodified from N.J.A.C. 10:37F-2.2(b)2), amendments concerning consumer participation in service planning are proposed. An added requirement states that the PA shall include the consumer and, if the consumer consents, the consumer's family, in service planning. Additional amendments provide that the consumer shall document lack of participation or disagreement with the IRP in the comments section, and that if the consumer refuses to give written authorization to release information, the team shall document in the consumer's record that efforts were made at each milestone to obtain such authorization.

N.J.A.C. 10:37F-2.4(d) (recodified from N.J.A.C. 10:37f-2.2(b)3) provides that the IRP shall reflect any other service in which the consumer participates and coordinative efforts, if any, in achieving the treatment goals and objectives.

At N.J.A.C. 10:37F-2.4(e) (recodified from N.J.A.C. 10:37F-2.2(b)4), proposed amendments specify that the PA shall train staff in the formulation and implementation, rather than "development" of an IRP.

At new N.J.A.C. 10:37F-2.4(f)1 (recodified from N.J.A.C. 10:37F-2.2(c)1)), proposed amendments state that changes in goals or objectives due to new information form in-depth and ongoing assessment or a change in the consumer's circumstances may qualify the review schedule for an IRP. In such circumstances, the IRP must be changed to reflect the new information. Another proposed amendment in this section requires that ongoing skill and resource

assessments be made prior to the plan review. At N.J.A.C. 10:37F-2.4(f)3, proposed amendments change the timeframe for the updating of the psychiatric evaluation from three to six months and delete subparagraphs (f)3i and ii as all consumers receiving psychiatric evaluations are all treated the same regardless of whether they receive medication.

New N.J.A.C. 10:37F-2.4(g)6 requires that progress within group and other PA activities be documented through a daily rating of the consumer's progress and participation which may either take the form of a written note or a rating scale. Rating must include consumer self-report as well and overall progress and participation for the week should be reflected in the weekly progress note.

N.J.A.C. 10:37F-2.5 Services to be provided

At 10:37F-2.5 (recodified from N.J.A.C. 10:37F-2.3), proposed amendments substantially change the delineation of partial care services by deleting subparagraphs (a)1i through v and replacing them with new paragraphs (b)1 through 11, as discussed below. At N.J.A.C. 10:37F-2.5(a) (recodified from N.J.A.C. 10:37F-2.3(a)), proposed amendments require that services must not exceed a 1:12 staff-to-consumer ratio based upon the active daily census and direct care staff, except where otherwise indicated in N.J.A.C. 10:37F-2.5(b)4. At new N.J.A.C. 10:37F-2.5(b) (recodified from N.J.A.C. 10:37F-2.3(a)1), proposed amendments delete the existing description of the core services and replace or supplement them with new requirements: (1) engagement strategies; (2) life goal

acquisition activities; (3) illness management and recovery activities; (4) skill development; (5) prevocational services; (6) medication-related services; (7) goal-oriented verbal counseling; (8) age-appropriate learning activities; (9) social/leisure activities; (10) psychiatric services; and (11) other planning activities, such as advanced directives and wellness and recovery action plans.

New N.J.A.C. 10:37F-2.5(c) requires the PA to develop written description of services, outlines and curricula for activities and interventions directly provided. Clinical records, schedules, rating forms of groups and other activities, log and other documents shall serve as evidence that these services have been provided.

New N.J.A.C. 10:37F-2.5(d) delineates requirements for off-site interventions. Off-site interventions can be provided as long as the consumer is accompanied/supervised by staff and the following conditions are met. Off-site interventions shall be: (1) individualized for each consumer and non-stigmatizing; (2) integrated as a subordinate component of the consumer's IRP, which clearly states each specific off-site intervention and how intervention relates to the overall achievement of the consumer's specific goals and objectives in the service plank, particularly in assisting to generalize skills to community setting. Services that are solely recreational or diversional in nature shall not be considered a PC activity; (3) properly documented in the consumer's record to include when the off-site activity commenced and terminated; and (4)

limited to a defined and measurable period of time. Off-site services provided weekly shall be generally less than 10 percent of an individual consumer's average active programming time in PC during the previous month. If off-site activities are greater than 10 percent additional justification is required in the consumer's record and may be subject to program audit by the Division. In no case may the time be more than 20 percent. The consumer must sign in at the site of the partial care program prior to participating in any off-site activity and sign out of the program after completion of the activity.

Transportation to and from the off-site activity shall not be counted as part of the partial care program activity time requirement unless the following conditions are met: (1) the PA has a staff person in the vehicle functioning as a counselor, and there are no more than four consumers in the vehicle; (2) if there are more than four consumers, a second staff person must accompany the counselor and function as a driver; and (3) the staff conducts activities during the period of transportation that meet all the requirements of the allowable activities of a partial care program.

At new N.J.A.C. 10:37F-2.5(e) (recodified from N.J.A.C. 10:37F-2.3(a)2), amendments have been proposed dealing with services that the PA may provide or arrange. At N.J.A.C. 10:37F-2.5(e)2 (recodified from N.J.A.C. 10:37F-2.3(a)2ii), a proposed amendment adds "medical" to the type of health care services that may be provided or arranged. At 10:37F-2.5(e)4 (recodified from N.J.A.C. 10:37F-2.3(a)2iv), proposed amendments change "financial services" to "financial literacy" to clarify that this service must provide greater consumer

autonomy and comprehension and add “saving strategies” to the list of services that must be provided.

At 10:37F-2.5(e)5 (recodified from N.J.A.C. 10:37F-2.3(a)2v), a proposed amendment specifies that prevocational services may include sheltered employment, job training, or volunteer work. At new N.J.A.C. 10:37F-2.5(e)6 (which includes some language from N.J.A.C. 10:37F-2.3(a)2v), proposed amendments specify the types of activities that would be considered vocational services, including some activities that were formerly considered prevocational – that is, transitional employment and consumer owned and operated businesses (which is proposed to be amended to owned and operated entrepreneurial businesses). Other vocational services proposed to be added to the rule are technical occupational skills training, college preparation, individualized job development and marketing to employers; while sheltered employment, job training, job placement, and volunteer work are proposed to be deleted from the rule.

Proposed new N.J.A.C. 10:37F-2.5(e)8 adds information regarding integrated treatment for co-occurring mental health and substance abuse disorders. At N.J.A.C. 10:37F-2.5(e)9 (recodified from N.J.A.C. 10:37F-2.3(a)2ix), a proposed amendment explains that residential services may include “assisting consumers to secure” the listed services, rather than just including the services themselves.

N.J.A.C. 10:37F-2.3(a)3, requiring Pas to develop procedures regarding medications is recodified as N.J.A.C. 10:37F-2.5(f).

At new N.J.A.C. 10:37F-2.5(G) (recodified from N.J.A.C. 10:37f-2.3(a)4), proposed amendments add “outlines and curricula for activities and interventions” to the written descriptions of services directly provided or arranged for, that must be developed by the PA.

N.J.A.C. 10:37F-2.6 Termination, transfer and referral of consumers

Several amendments are proposed at N.J.A.C. 10:37F-2.6 (recodified from N.J.A.C. 10:37F-2.4) regarding termination, transfer and referral of consumers. New N.J.A.C. 10:37F-2.6(b) state that discharge criteria shall be identified at the time of admission and shall include the steps necessary to facilitate community integration. The criteria shall be documented in the initial service plan recommendations and the IRP.

New N.J.A.C. 10:37F-2.6(c) requires that, in the case of transfers, providers prepare a summary at the time of discharge communicating critical information and forward it to the receiving agency. New N.J.A.C. 10:37F-2.6(d) (recodified from N.J.A.C. 10:37F-2.4(a)1) lists the specific reasons for termination from the program. At new N.J.A.C. 10:37F-2.6(i) (recodified from N.J.A.C. 10:37F-2.4(a)6), proposed amendments require that a termination or transfer summary shall be written within 30 days of the termination or transfer, respectively.

Existing N.J.A.C. 10:37F-2.5, Management functions is recodified as N.J.A.C. 10:37F-2.7; N.J.A.C. 10:37F-2.6, Quality assurance functions, is

recodified as N.J.A.C. 10:37F-2.8; N.J.A.C. 1o:37F-2.7, Therapeutic environment is recodified as N.J.A.C. 10:37F-2.9.

N.J.A.C.10:37F-2.10, Staffing

N.J.A.C. 10:37F-2.10 (recodified from N.J.A.C. 10:37F-2.8) delineates staffing requirements and contains the following proposed amendments. "Qualified personnel" has been replaced with "personnel who are licensed, when required, appropriately credentialed, culturally competent and sufficiently trained" to provide PC services in accordance with this Chapter at N.J.A.C. 10:37F-2.10(a). New N.J.A.C. 10:37F-2.10(e) has been added, describing continuing education for staff. The PA shall make continuing education available in order to ensure that staff has the competencies necessary to deliver the core program areas.

Qualifications for the program director, at N.J.A.C. 10:37F-2.10(b)1.iii), have been amended to state so that a person may posses a relevant professional credential, such as licensed social worker, licensed professional counselor, licensed rehabilitation counselor, licensed clinical alcohol and drug Counselor, licensed psychologist, advanced practice nurse or masters of science in nursing with the requisite number of years of experience.

At N.J.A.C. 1o:37F-2.10(b)2 (recodified from N.J.A.C. 10:37F-2.8(b)2), a proposed amendment specifies that the medical director or supervising psychiatrist shall be " a physician licensed to practice in the State of New Jersey

and be board certified or eligible in psychiatry," rather than just be "board eligible or certified."

N.J.A.C. 10:37F-2.10(b)3 has been amended so that the direct care supervisor must be "on-site" and may hold a master's degree in a human services, mental health or rehabilitation field and may possess a relevant professional credential such as licensed social workers, licensed professional counselors, licensed rehabilitation counselors, licensed clinical alcohol and drug counselor, licensed psychologists or master of science in nursing.

N.J.A.C. 10:37F-2.10(b)4 has been amended so that the primary case coordinator or counselor may posses a credential such as a certified psychiatric rehabilitation practitioner, licensed associate counselor, bachelors in social work, certified rehabilitation counselor, certified alcohol and drug counselor bachelors in rehabilitation, or a bachelor of science in nursing.

N.J.A.C. 10:37F-2.10(b)5 has been amended so that the mental health services worker may possess a credential, such as a certified psychiatric rehabilitation practitioner, community mental health associate.

The following proposed amendments appear in proposed paragraphs (c)1 and 2 added to N.J.A.C. 10:37F-2.8(c), recodified as N.J.A.C. 10:37F-2.10(c), regulating the delivery of services to consumers with integrated treatment for co-occurring mental health and substance use disorders (mental illness and substance abuse) disorders. Qualifications for the primary staff providing pre-vocational services must include one year's experience in providing services such as supported employment or job coaching, vocational evaluation, welfare to

work, community rehabilitation services, transitional employment, other work experience programs for consumers and recent relevant training or possess one of the following credentials: certified rehabilitation counselor, licensed rehabilitation counselor, master's or bachelor's degree in rehabilitation counseling, certified psychiatric rehabilitation practitioner (CPRP), or vocational instructor as defined by the New Jersey Board of Education. Qualified staff shall maintain their knowledge and expertise by continuing to receive recent, relevant training and continuing education. Qualifications for the primary staff providing integrated treatment for co-occurring mental health and substance use disorder services must follow the requirements as set forth by the Alcohol and Drug Counselor Committee of the State Board of Marriage and Family Therapy Examiners

Social Impact

Adult partial care services are designed to address the mental health needs of adults with serious and persistent mental illness. The rules proposed for readoption with amendments are expected to positively impact those individuals by establishing standards which will continue to promote the effective delivery of appropriately prioritized quality services. Implementation of these services and standards is expected to promote greater independence and improved quality of life, as well as reduced hospitalizations, among consumers receiving the services. Consumers will also benefit from the incorporation of wellness and recovery principles into Partial Care standards, as

this philosophy emphasizes the dignity and right to self-determination for each consumer. The proposed amendments reflect evidence-based practices which will lead to better outcomes for consumer, enhancing their integration into the community and overall quality of life.

Additionally, the rule proposed for readoption with amendments will assist providers in attaining their goal of providing high quality and well focused services. The proposed amendments provide clearer direction and informative detail regarding the responsibilities of providers.

Finally, the public will benefit because the supportive services offered by the Partial Care program will reduce the risks of expensive hospitalization and will assist consumer in becoming full, contributing members of society.

Economic Impact

The rules proposed for readoption with amendments delineate performance requirements which are not expected to increase costs. In fact, many of the proposed amendments streamline or reduce administrative requirements and thus, will result in reduced costs for providers. For example, proposed amendments at N.J.A.C. 10:37F-2.4(f)3.i change the required frequency of the psychiatric evaluation from four times per year to twice per year, resulting in an expense reduction for providers. In addition, reporting, recordkeeping, and eligibility requirements have been revised so that they are

now consistent with requirements delineated in state Medicaid regulations, eliminating duplication and heightening administrative efficiency for providers. Further, because the vast majority of providers receive Medicaid, Division or private insurance funds to deliver partial care services, the Department believes that such providers will not experience any negative economic impact.

Of course, consumers of Partial Care Services will benefit economically from these standards by receiving quality services at no additional personal expense. New Jersey taxpayers benefit from the effective delivery of these services because the services reduce the need for much more expensive psychiatric hospitalizations.

Federal Standards Statements

The rules proposed for readoption with amendments are not subject to any Federal standards or requirements. Therefore, a Federal standards analysis is not required.

Jobs Impact

The rules proposed for readoption with amendments would neither generate nor cause the loss of any jobs in the State.

Agriculture Industry Impact

The rules proposed for readoption with amendments will have no impact on the agriculture industry in this State.

Regulatory Flexibility Analysis

Some agencies providing partial care services may be small businesses, as that term is defined by the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The rules proposed for readoption with amendments set forth reporting, recordkeeping, and compliance requirements necessary for the efficient operation of the program. The rules require providers to develop and maintain for each consumer an initial service plan, a comprehensive assessment, a psychiatric evaluation, an individualized recovery plan, progress notes, and a termination summary (when applicable). The rules also set forth staffing requirements and responsibilities.

Compliance with these provisions would not require the procurement of outside professional services, nor would providers need to expend capital costs to comply with these rules, as discussed in the Economic Impact above. The rules are performance-based and focus on the empowerment of the consumer through requirements for consumer participation in planning and decision-making.

The reporting, recordkeeping and compliance requirements imposed upon provider agencies must be uniformly applied, regardless of the size of the provider agency to ensure that individuals with mental illness receiving these services throughout the State do so with the assurance of basic minimum standards of quality. These standards are important because individuals receiving them have been either hospitalized for psychiatric reasons or are at risk such costly and restrictive hospitalization.

Smart Growth Impact

The rules proposed for readoption with amendments will have no impact on the achievement of smart growth and implementation of the State Development and Redevelopment Plan.

Full text of the rules proposed for readoption may be found in the New Jersey Administrative Code at N.J.A.C. 10:37F.

Full text of the proposed amendments follows (additions indicated in boldface thus; deletions indicated in brackets [thus]):

Subchapter 1. General Provisions

10:37F-1.1 Scope and purpose

(a) The rules in this chapter shall apply to all [Division funded] providers of partial care services (PC) for adults.

(b) The purpose of PC services is to **[**provide comprehensive, non-residential, structured programming for**]** assist individuals with severe mental illness to achieve community integration through valued living, learning, working, and social roles and **[**The therapeutic milieu of these programs provides rehabilitation and intensive support**]** to prevent hospitalization and relapse [and to assist in the development of community living skills**].** The role of PC is therefore to facilitate consumer integration into the community, not to become a permanent outcome although it is recognized that some consumers may need the support of PC for long periods of time. This balance between recovery and clinical services is accomplished through the provision of individualized, comprehensive, non-residential, structured programming which provide, but are not limited to, [PC services include] counseling, case management, psychoeducation, pre-vocational services, social and [recreational] leisure services, and psychiatric services, and shall be available to eligible individuals on **[**a half-day or full-day**]** an hourly basis for up to five hours per day at least five times per week.

10:37F-1.2 Guiding principles

(a) The following concepts of recovery and wellness shall serve as the guiding principles in the delivery of partial care services:

1. Consumers should have a basis to expect that, as a result of their involvement with this program, they will be able to better manage their illness and improve the quality of their life;
2. Partial care programs shall identify and build upon each recovering individual's strengths and areas of health in addressing his or her needs;
3. The environment in which partial care services are delivered shall encourage hope and emphasize individual dignity and respect;
4. As recovery is most often a process, not an event, the provider shall address the needs of people over time and across different levels of disability;
5. Recovery principles shall be applied to the full range of engagement, intervention, treatment, rehabilitation and supportive services that a person may need;
6. As a recovery-oriented system, the partial care program shall offer a high degree of:
    i. accessibility; and
    ii. sustainable effectiveness in engaging and retaining persons in care such that they can achieve the highest degree of stability and recovery over a long period of time;

7. Whenever possible, the services shall be provided within the person's own community setting, using the person's natural supports; and
8. The service system shall help the person achieve an improved sense of mastery over his or her condition and shall assist the person in regaining a meaningful, constructive sense of membership in the community.

(b) The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, (DSM), is incorporated by reference into this Chapter. Copies of the DSM may be obtained from the American Psychiatric Association, 1400 K Street N.W., Washington, D.C. 20005.

10:37F-1.3 Definitions

The following words and terms, as used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise:

"Active treatment" means a process initiated at the point of intake for a partial care program and consists of the assessment, treatment, psychiatric rehabilitation and discharge planning phases of mental health services. Active treatment includes an integrated, comprehensive, and complementary schedule of treatment services for the purposes of maximizing a consumer's independence

and community living skills to promote community integration, achieving valued roles and reducing unnecessary hospitalizations.

"Advanced practice nurse" means an individual certified as an advanced practice nurse by the New Jersey State Board of Nursing.

"Certified psychiatric rehabilitation practitioner" means an individual who has fulfilled all the eligibility requirements and passed a comprehensive, standardized written examination as defined by the Certification Commission for Psychiatric Rehabilitation.

"Clinician" means a mental health professional possessing a Master's or Doctoral degree from an accredited university in a field such as psychiatry, psychology, social work, psychiatric nursing or rehabilitation counseling, including but not limited to a licensed professional counselor. In addition to the degree, the applicable training must be completed including the appropriate residency (fellowship), internship or student placement required by the professional standards of the respective discipline as well as the applicable state license. A clinician may also have the credentials to be a qualified addictions staff person.

“Community Mental Health Associate” means a Community Mental Health Associate as defined by the Addiction Professional Certification Board, Inc., 1200 Tices Lane, East Brunswick, New Jersey.

“Direct care staff” means those personnel whose primary function is face-to face interaction with the consumer providing the therapeutic contact necessary to achieve the consumer’s treatment goals.

"Division" means the Division of Mental Health **[**and Hospitals**]** Services in the Department of Human Services.

"Educational services" means a formal educational course of study leading to a degree, certificate or graduation from an accredited institution or program and may include basic educational courses, special educational courses, General Education Diploma (G.E.D.), and pre-college preparation.

"Individualized recovery plan” (IRP) means a consumer directed, individualized treatment plan, based upon the comprehensive assessment, developed by the consumer in collaboration with family members, significant others and partial care staff that identifies clinical needs, current status and specific goals and objectives. The IRP identifies specific interventions, measurable outcomes and is revised on a regular basis to reflect the individual's current status and achievement of goals.

"Interdisciplinary treatment team (IDTT)" means a team of individuals consisting of a psychiatrist and/or an advanced practice nurse, clinician, rehabilitation and other counselor(s), consumer, family member with consent**,** direct partial care staff, R.N. and others involved with meeting the consumer's treatment needs.

“Licensed professional counselor” means an individual licensed as a professional counselor as defined by Professional Counselor Examiners Committee of the New Jersey State Board of Marriage and Family Therapy Examiners

“Licensed associate counselor” means an individual licensed as an associate professional counselor as defined by Professional Counselor Examiners Committee of the New Jersey State Board of Marriage and Family Therapy Examiners

"Mental health services worker" means an individual who possesses a bachelor's degree or associate's degree in psychosocial rehabilitation or mental health services, or related life or work experience in mental health, such as assuming leadership roles during participation in mental health services or mental health consumer initiatives.

"Off-site interventions" means planned mental health programming provided during hours of partial care at a location other than that of the program site in order to assist the individual to apply and/or practice critical community skills learned in the PC.

"Partial care" means an individualized, outcome-oriented mental health service which provides a comprehensive, structured, non-residential, interdisciplinary treatment and psychiatric rehabilitation program in a community setting to assist consumers who have serious mental illness in increasing or maximizing independence and community living skills and enhancing the quality of their lives. Partial Care services are offered to an individual age 18 or older with a primary psychiatric disorder that is accompanied by an impaired ability to perform living, learning, working or social roles. Partial care services support consumer stabilization and community integration and are alternatives to more intensive acute interventions. Partial care services provide active treatment and psychiatric rehabilitation for consumers who do not require inpatient hospitalization but require support and structured programming.

["Partial care services (PC)" means comprehensive, structured, non-residential health services provided in a community setting to adult clients who have serious mental illness.]

"Pre-vocational services" means interventions, strategies and activities within the context of a partial care program that assist individuals to acquire general work behaviors, attitudes and skills needed to take on the role of worker and in other life domains, such as responding to criticism, decision making, negotiating for needs, dealing with interpersonal issues, managing psychiatric symptoms and adherence to prescribed medication directions/schedules. Examples of interventions not considered pre-vocational include technical occupational skills training, specific college preparation not incidental to general community integration skills, and student education, including preparation of school-assigned class work or homework, and individualized job development.

"Programs of assertive community treatment (PACT)" means mental health rehabilitative services which are delivered in a self-contained treatment program provided by a service delivery team and managed by a qualified program director, that merge treatment, rehabilitation, and support services which are individualized and tailored to the unique needs and choices of the individual receiving the services.

"Provider agency (PA)" means a public or private organization which **[**has a contract with the Division to provide PC services**]** provides partial care services to adults with serious mental illness, as set forth in this Chapter.

["Psychoeducation services" means a mutual exchange of information and

education between the professional and client or the professional and family members in order to increase the likelihood of family and community support to the client and to reduce the probability of client decompensation. Information may address etiology and symptoms characteristic of the client's mental illness, effects of medication, coping skills, daily living skills, community resources and supports, and similar mental health service-related matters.]

"Qualified addictions staff" means individuals credentialed to provide supervision, clinical or direct care as defined in the 'Alcohol and Drug Counselor Licensing and Certification Act, N.J.S.A. 45:2D–1 et seq. and to provide mental health services within partial care.

"Registered nurse (RN)" means a registered professional nurse licensed by the New Jersey Board of Nursing.

"Rehabilitation counselor" means an individual licensed by the Professional Counselor Examiners Committee of the New Jersey State Board of Marriage and Family Therapy Examiners (licensed rehabilitation counselor or LRC), certified as a certified rehabilitation counselor (CRC) by the Certification in Rehabilitation Counseling Board and/or possessing the education, training and experience sufficient to sit for either credential.

“Skill development” means acquiring the knowledge, attitudes and specific behaviors that lead to the mastery of the identified critical competency and its use when and where it is needed for valued community role functioning.

“Social worker” means an individual defined by the New Jersey Board of Social Work Examiners as either a certified social worker (CSW), licensed social worker (LSW),licensed clinical social worker (LCSW),

"Special minimum wage certificate" means a certificate issued to a provider by the U.S. Department of Labor pursuant to 29 CFR sections 525, which permits a worker with a disability to be paid at a rate below the rate that would otherwise be required by statute.

"Therapeutic subcontract work activity" means production, assembly and/or packing/collating tasks for which individuals with disabilities performing these tasks are paid less than minimum wage, and pursuant to 29 CFR section 525, a "special minimum wage certificate" has been issued to the organization/program, by the U.S. Department of Labor.

“Therapeutic token economies” mean learning reinforcement strategies which are medically necessary, such as those which promote the consumer’s progress in learning critical skills. Non-therapeutic token economy activities, such as those used for the recruitment of beneficiaries, are not medically necessary and

therefore not therapeutic and are prohibited. Token economy activities if provided, like other medically necessary plan of care activities, shall be implemented in accordance with an individual's plan of care.

"Vocational services" mean those interventions, strategies and activities that assist individuals to acquire skills to enter a specific occupation and take on the role of colleague (that is, a member of a profession) and/or assist the individual to directly enter the workforce and take on the role of an employee, working as a member of an occupational group for pay with a specific employer.

SUBCHAPTER 2. PARTIAL CARE STANDARDS

10:37F-2.1 Admission **[**and intake**]** criteria

(a) First priority for admissions into PC services shall be given to persons with severe and persistent mental illness in accordance with target populations, as defined in N.J.A.C. 10:37-5.2.

1. **[**Inclusionary**]** The provider agency shall utilize the following inclusionary and exclusionary admission criteria, which are **[**not inconsistent with contract provisions, shall be written and utilized in intake procedures**]** designed to assure the clinical appropriateness of each admission.

(b) Inclusionary criteria: In order to be considered eligible for partial care services, an individual must:

1. Demonstrate impaired functioning, that leads to a need to learn critical skills in order to achieve valued community roles and community integration, in at least one of the following domains on a continuing and intermittent basis for at least one year:

i. Personal self-care;

ii. Interpersonal relationships;

iii. Work;

iv. School;

v. Ability to live in the community; or

vi. Ability to acquire and/or maintain safe, affordable housing and is at risk of requiring a more restrictive living situation;

2. Be 18 years of age or older;

3. Demonstrate or possess clinical evidence to justify the necessity for partial care services. This necessity must be confirmed by the psychiatrist or advanced practice nurse and interdisciplinary treatment team and documented in the record;

4. Demonstrate the need for psychiatric rehabilitation and active treatment of no less than two hours and no more than 25 hours weekly;

5. At the time of referral or as a result of psychiatric evaluation provided or arranged for by the PA, have at least one of the following primary DSM IV diagnoses on Axis I:

i. Schizophrenia or Other Psychotic Disorders (298.9);

ii. Major Depressive Disorder (296.xx);

iii. Bipolar Disorders (296.xx, 296.89);

iv. Delusional Disorder (297);

v. Schizoaffective Disorder (295.7); or

vi. Affective Disorders (300.xx);

6. Have a covered psychiatric disorder diagnosis consistent with codes, axis I – V, of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR), incorporated by reference, as amended and supplemented, including some 301.XX Axis II codes if the personality disorder is considered in the severe range and the individuals are at high risk of psychiatric hospitalization as a result; and

7. At the time of referral, meet one or more of the following criteria:

i. Acute service need:

(1) One or more contacts with a screening center or emergency service mental health program;

(2) Two or more admissions to an inpatient behavioral health program including STCF; or

(3) One psychiatric hospitalization of three months or longer;

ii. A Global Assessment of Functioning (GAF) Scale score of between 11 and 70, as found in the Diagnostic and Statistical Manual of Mental Disorders, page 32.

(c) Exclusionary criteria: A consumer who presents any of the following criteria shall be excluded from participation in partial care services:

1. A primary diagnosis of substance use/dependence;
2. A current danger to self, others or property;
3. A primary diagnosis of “developmentally disabled”; or
4. Current participation in a PACT program, unless authorized in accordance with N.J.A.C. 10:76.

[(b) The initial contact shall serve to orient and engage new clients, and facilitate continuity of service.

1.The PA shall have a procedure for the recording of pertinent information during the potential client's contact with the PA.]

10:37F-2.2 Intake procedures

(a) The PA shall develop and implement an intake process that provides [an opportunity] a basis for assessment of an applicant's eligibility for service and the formulation of an initial service plan to guide initial services which is mutually developed by the consumer and a staff member. All intake procedures shall be guided by a consumer's preferences and goals with regard to treatment and community living.

1. The initial contact shall serve to orient and engage new consumers in a culturally and linguistically appropriate manner, and facilitate continuity of service.

2. Intake procedures shall be designed to facilitate program participation at the earliest appropriate opportunity. Completion of the formal intake process shall not preclude an otherwise eligible consumer from participating in program activities or receiving services on a provisional or try-out basis.

3. The PA shall train staff regarding appropriate responses to inquiries for service and shall document such training.

4. The PA shall maintain a system to schedule face-to-face intake appointments within 14 calendar days.

   i. The intake process for each consumer shall include a minimum of one face-to-face interview, during which the information listed at (b) below shall be obtained.

   ii. If the [client] consumer cannot be immediately scheduled, the PA shall contact the [client] consumer within two working days to arrange for an initial intake appointment.

5. The intake process shall include an orientation to the program and an explanation of the consumer's rights and grievance procedure. The PA shall also post the grievance procedure in a prominent location within the agency and make copies of N.J.A.C. 10:37-4.5, Client rights, and 10:37-4, Client complaint/agency ombuds procedure, available to consumers upon request.

[4. The PA shall develop a written policy for minimum client information required for intake. A major purpose of this policy shall be

to ensure that there is an adequate client assessment without undue delay of service.

6. The PA shall develop a procedure for clients who cannot be served immediately, but for whom interim support is needed to address emergent needs. In all cases, a determination of the clients' interime medication needs shall be made. These interim support services shall be documented.

(c)The PA shall develop and implement an intake process that provides an opportunity for assessment of an applicant's eligibility for service and the formulation of a plan to guide initial services which is mutually developed by the client and staff member.

2. Intake procedures shall be designed to facilitate program participation at the earliest appropriate opportunity. Completion of the formal intake process shall not preclude an otherwise eligible client from participating in program activities or receiving services on a provisional or try-out basis.
3. The intake process shall include a minimum of one face-to-face interview.**]**

[3. There shall be] (b) In order to ensure that there is an adequate basis for a timely and accurate consumer assessment, the provider agency shall develop and maintain written policies and procedures which require that the following information be documented for all intake interviews

[conducted. These procedures shall include requirements for documenting the following]:

[i] 1. Basic demographic information, including emergency contact person;

[ii] 2. Presenting problems and reason for referral, including consumer interests and preferences in achieving valued community living, learning, working or social roles;

[iii] 3. A medical history, including a brief history of the illness and previous services received at agency and elsewhere, a consumer self report of response to previous treatment, a completed current mental status evaluation, medication information; current mental health and social service providers; and any allergies;

[iv. Medical information;

v. Current mental health service providers and other social service providers;]

[vi.] 4. A signed [consent] authorization for release of information, in accordance with all applicable legal requirements;

[vii.] 5. Basic family and social supports;

[ix.] 6. Legal information relevant to treatment;

[x.] 7. Basic [chemical] substance dependency information;

8. Basic employment and educational history; and

[xi.] 9. Risk factors (for example, under what circumstances the [client] consumer may be a danger to self or others or present a risk of sexually predatory behavior).

[4.] (c) The PA shall develop and implement a written procedure [which] that requires a review of all intakes that result in a determination that a [client] consumer may be denied service.

[5.] (d) The PA shall develop and implement written procedures that require the PA to maintain contact with any [client] consumer who is waiting for service in order to ensure that each [client's] consumer's emergent needs are identified and met.

[6.] (e) An initial service plan shall be completed during the intake process. This plan shall address the [client's] consumer's immediate needs and concerns, with special attention to urgent presenting problems, to meet immediate needs for food, clothing, shelter and medication.

[7.] 1. The initial service plan shall be documented in the progress notes and shall include interventions utilized, such as prevocational or counseling services.

[8.] 2. The initial service plan shall be revised as needed until the [comprehensive service plan] individualized recovery plan is developed.

3.The PA shall develop a formal procedure for updating the initial service plan, and create an Individualized Recovery Plan [which] that shall be completed within six weeks of intake and shall involve supervisory personnel.

[9. The intake process shall include an orientation to the program and an explanation of the client's rights and grievance procedure. The PA shall also post the grievance procedure in a prominent location within the agency and make copies of N.J.A.C. 10:37-4.5, Client rights, and 10:37-4, Agency ombuds procedure, available to clients upon request.**]**

10:37F-**[**2.2**]**2.3 Assessment **[**and service planning**]**

(a) PA staff shall complete a written comprehensive assessment for each [client] consumer prior to development of the [comprehensive services] individualized recovery plan. The comprehensive assessment provides the PA and consumer with an initial profile of the strengths and barriers related to community integration, achievement of chosen valued roles and which issues or problems must be addressed in what priority.

1. The PA's written procedures shall require that every comprehensive assessment include at a minimum, the assessment of the [client's] consumer's skill and resource strengths, and [deficits] barriers to attainment of the

consumer's self-expressed goals related to community integration and living, learning, working and social role recovery in the following areas:

i. [Motivation, including, but not limited to, willingness to participate] The consumer's interest in and strengths and goals related to participation in the program;

ii. Social and [recreational] leisure functioning including, but not limited to, ability to make friendships, communication skills and hobbies;

iii. Emotional and psychological characteristics including, but not limited to, mental status, trauma and abuse history, if applicable, understanding of their own illness, and coping mechanisms;

iv. [Physical health] A review of medical systems including, but not limited to, applicable allergic and adverse medication reactions and screening for current physical, emotional, sexual abuse and/or neglect;

v. – x. (No change.)

[1.] 2. The written comprehensive assessment shall [include sufficient] clearly indicate justification for the need for PC services.

[2.] 3. The written comprehensive assessment shall clearly indicate the consumer's interest or the situational urgency with which a barrier must be addressed in order to prioritize its intervention in the individualized recovery plan.

4. The written comprehensive assessment shall describe both the skills and resources needed to attain the consumer's expressed goals and values roles, including quality of life based upon, but not limited to, consumer interviews, direct observation and information obtained from family members and other collaterals.

[3] 5. The written comprehensive assessment shall be completed within [three months] one month after acceptance to the program and prior to development of the [comprehensive service] individualized recovery plan.

[4] 6. The written comprehensive assessment shall include a documented psychiatric evaluation completed within two [four] weeks of admission which shall reflect consideration of the following:

i. Diagnosis (Axis I- [III] V) in conformance with the Diagnostic and Statistical Manual of Mental Disorders IV (DSM-IV (available from the American Psychiatric Association, 1400 K St., NW, Washington, DC 20005), incorporated herein by reference, as amended and supplemented;

ii. – viii. (No change.)

ix. Family psychiatric history[.]; and

x. The consumer's expressed interests, preferences, strengths and goal(s) related to valued community roles and quality of life.

[5] 7. The PA shall make reasonable efforts to involve the family and significant others in the assessment process to the extent possible.

8. The PA shall continue to conduct functional and resource assessments of those areas, goals and objectives prioritized from the comprehensive assessment and selected for formulation in the individualized recovery plan. These on-going assessments shall be completed prior to the three month review of the IRP and shall be documented in the clinical record.

10:37F-2.4 Recovery Planning

[(b)] (a) The individualized recovery plan (IRP) is designed to assist the consumer in organizing, reviewing and modifying an array of treatment and rehabilitation services which supports his or her identified path to recovery. The [comprehensive service plan] IRP shall be based on specific areas of interest identified by the consumer and urgent problems or barriers that have been prioritized from the comprehensive assessment.

1. It shall be [completed within three months of] formulated and implemented at the completion of the comprehensive assessment but no later than six weeks from the [client's] consumer's admission to the program.

2. Areas identified in the comprehensive assessment but not initially addressed in the IRP at intake, should be reviewed and formulated at subsequent IRP reviews or when re-prioritized by the consumer and

PA. The [comprehensive service plan] IRP shall reflect agreement and mutual understanding between the [client] consumer and the program staff on goals to be achieved by the [client] consumer and program activities to address these goals.

[1.] (b) The [comprehensive service plan] IRP, developed with the consumer**,** shall include the following:

[i.] 1. Language that can be easily understood by the [client] consumer;

[ii.] 2. The signatures of the [client], consumer primary case coordinator or counselor and direct care staff supervisor;

[iii.] 3. The psychiatrist's or advanced practice nurse's signature, which shall reflect the [psychiatrist's] direction of the course of treatment;

[iv.] 4. To assure family participation in developing the IRP and revisions, the PA shall seek the input of family members at each service planning milestone, provided that the consumer has given

written consent to release information related to the treatment of his or her mental illness. **[**Involvement of family members and others in the development of the plan, when applicable;]

[v.] 5**.** The [client's] consumer's self-stated overall goals [and objectives] related to chosen, valued role(s) and specific plans to achieve these roles, with target dates for achievement, including further in-depth and ongoing assessment in the identified areas;

[vi. Specific partial care services to be provided to the client;**]**

[vii.] 6. Specific interventions, strategies and activities to implement the [comprehensive service plan] IRP, including clear reference to necessary off-site services to assist in the transfer of learning; [and]

[viii.] 7. Identification of staff responsible for implementing each intervention [.] and

8. A comment section under which the consumer states in their own words any concerns, agreements or disagreements with either the development or final IRP.

[2.] (c) The PA shall **[**make every effort to**]** include [client] consumer and

family (if the consumer consents) participation in service planning. The [client's] consumer's signature on the IRP shall indicate that the [client] consumer was involved in the formulation of the plan or that the [client] consumer reviewed and approved of the plan. [In the event that the client] If the consumer is not involved in the development of the plan or the [client] consumer does not agree with any part of the plan, [program staff] the consumer shall document [client's] his or her lack of participation or disagreement in the comments section of the IRP [clinical record].

1. If the consumer refuses to give written authorization to release information, the team shall document in the consumer's record that efforts were made at each milestone to obtain such authorization.

[3.] (d) The [comprehensive service plan] IRP shall reflect any other service in which the [client] consumer participates and coordinative efforts, if any, in achieving the treatment goals and objectives.

[4.] (e) The PA shall train staff in the [development] formulation and implementation of [a comprehensive service plan] an IRP.

[(c)] (f) The comprehensive IRP [service plan] shall be periodically reviewed to determine the [client's] consumer's need for continued services and revised as necessary.

1. The [comprehensive service plan] IRP shall be reviewed and revised within three months of its development, every three months for the first year, and every six months thereafter[.] unless goals or objectives change due to new information from the in-depth and ongoing assessment or a change in the consumer's circumstances. The IRP shall then be immediately changed to reflect this new information. A review of ongoing skill and resource assessments shall be made prior to the plan review. Documentation of the [comprehensive service plan] IRP reviews shall include signatures of the [client] consumer, direct care staff, supervisor and psychiatrist.

2. [Comprehensive service plan] IRP reviews shall reflect the [client's] consumer's changing needs and progress toward goals. Documentation shall include a determination of the need for continued PC services and any revisions in service provision. Consideration of the expected benefits of continued services and the risk of service termination shall be included.

3. The PA shall update the psychiatric evaluation[:

i. At] at least every [three] six months, for every consumer receiving partial care services, based on information from the prescribing physician for [clients] consumers receiving medications for their psychiatric condition; and

ii. Every six months for all other [clients] consumers who are not receiving medication for their psychiatric condition or who receive their medication from a psychiatrist not connected to the PA.]

4. As the [client] consumer progresses, treatment goals shall address a gradual reduction in services or a transition to less intensive services.

5. Maintenance of functioning shall be a legitimate service goal if it is appropriate to the [client's] consumer's needs.

[(d)] (g) The PA shall write progress notes in the [client's] consumer's record at least weekly, as follows:

1. The PA staff shall document development of the [comprehensive service plan] IRP during the initial three month period in the progress notes.

2. Each weekly progress note shall address:

i. The [client's] consumer's response to at least one specific treatment intervention identified in the [service plan] IRP;

ii. A summary of PC activities in which the [client] consumer participated during that week;

iii. The [client's] consumer's general level of participation and clinical progress in the program for that week; and

iv. Significant events that occurred during that week.

3. Within every three-month period, the progress notes shall reflect the [client's] consumer's progress towards all goals and objectives included within the [comprehensive service plan] IRP.

4. Progress notes shall contain documentation by PA staff of all known current medications prescribed to address both psychiatric and medical conditions. All medications and changes in the medication regimen shall also be documented by PA staff on a medication summary sheet.

5. Progress notes shall be legibly written, signed and dated.

6. Progress within group and other PA activities shall be documented through a daily rating of the consumer's progress and participation which

may either take the form of a written note or a rating scale. Rating shall include consumer self-report as well.

i. Overall progress and participation for the week should be reflected in the weekly progress note.

10:37F-[2. 3] 2.5 Services to be provided

(a) The PA shall provide, or arrange for, a range of services to effectively address the holistic needs of the [client] consumer. Service provision shall be coordinated with other service providers. Services must not exceed a 1:12 staff to consumer ratio based upon the active daily census and direct care staff, except as indicated in (b)4 below.

[1.] (b) The PA shall directly provide the following core services:

[i. Counseling/case management services, which include evaluation, service planning, and personal intervention;

ii. Psychoeducational services for clients and families, which include mental health and medication education;

iii. Prevocational, vocational or educational services as appropriate,

directed toward maximizing vocational potential, which include work readiness, prevocational experiences, prevocational training and counseling, prevocational assessment and planning;

iv. Social/ recreational services, which include independent living skills training, client government, goal oriented social club activities, goal oriented recreational and cultural activities; and

v. Psychiatric services, which include assessment and ongoing treatment supervision.**]**

1. Engagement strategies shall be designed to connect with consumers over time in order to develop a commitment on their part to enter into therapeutic relationships supportive of the individual's recovery. This service may include, but is not limited to, activities such as initial contacts with potential program participants, as well as continued efforts to engage individuals to participate in program services;

2. Life goal acquisition activities designed to assist a consumer to identify, attain and retain over time, personally meaningful goals which help the person resume normal functioning in valued life roles in self-chosen

community environments. Examples of rehabilitation goals include but are not limited to returning to work or school, returning to adult care-giving or parenting roles, resuming roles as a spouse or significant other, becoming a member of a religious community, or becoming a neighbor;

3. An illness management and recovery program, which is comprised of a broad set of strategies and activities that help consumers collaborate with practitioners to identify and pursue personally meaningful recovery goals and which founded upon a core set of interventions that include: psycho education, social skills training, cognitive-behavioral therapy, motivational interviewing and behavioral tailoring, and relapse prevention techniques. . This is accomplished by helping people to develop coping strategies and skills that reduce the individual's susceptibility to the illness, provide assistance and support to effectively manage symptoms to prevent relapse and rehospitalizations, and reduce distress to the point that the consumer is able to enjoy an improved quality of life. They are intended to be both didactic and practical in nature and can be provided in both group and individual settings. Such services will be provided directly to consumers and in support of family members and/or other significant individuals important to the consumer. The services shall include, but are not limited to:

i. Coping skills, adaptive problem solving, and social skills training that teach individuals strategies to self-manage

symptoms and personal stress and strengthen life skills and abilities to attain their recovery goals;

ii. Psycho education that provides factual information, recovery practices, including evidence-based models, concerning mental illness that instills hope and emphasizes the potential for recovery. Such services will be geared toward the consumer developing a sense of mastery over his or her illness and life, and shall also be effective in reducing relapse and rehospitalizations. It may also provide support to the consumer's family and other members of the consumer's social network to help them manage the symptoms and illness of the consumer and reduce the level of family and social stress associated with the illness;

iii. Development of a comprehensive relapse prevention plan that offers skills training and individualized support focused on self-management of mental illness and other aspects of recovery, including early recognition, identification and management of symptoms and positive coping strategies and development of supports to reduce the severity and distress of disturbing symptoms. Special attention shall be placed on understanding, recognizing and monitoring of stressors that have triggered return of

persistent symptoms in the past and adaptive problem solving techniques shall be applied to avoid recurrences in the future. As this process of mastery over the illness evolves, the practitioner will explore and develop a new sense of personal identity with the consumer, and examine with him or her the potential for growth beyond the mental illness;

iv. Dual disorder education which provides basic information to consumers, family members or other significant individuals on the nature and impact of substance use and how it relates to the symptoms and experiences of mental illness and its treatment, as well as upon the attainment of one's personal recovery goals;

v. Medication education to be provided within the context of a collaborative and therapeutic relationship. Consumers will be provided with adequate information in an understandable format regarding medications' relative effectiveness and safety in order to make an informed decision. Interventions such as medication self-management, behavioral tailoring, simplifying a consumer's medication regimen, and motivational interviewing assist and support consumers' in adhering to their medication regimens. Practitioners will specifically

review with the consumer how medication management issues will impact their personal recovery goals and will be responsible for involving family members whenever possible; and

vi. Wellness activities that are consistent with the consumer have self-identified recovery goals. Wellness activities may address common physical health problems such as tobacco dependency, alcohol use, sedentary lifestyle and lack of physical exercise, and overeating and/or poor nutrition. Other wellness services may address goals such as constructive use of leisure time and fulfilled spirituality and creativity pursuits;

4.Skill development needed for consumer chosen community environments, facilitating consumer-directed recovery and re-integration into valued community living, learning, working and social roles by developing critical competencies and skills. Skill development can be accomplished through either individual or group instruction; however, the direct staff-to-consumer ratio in such circumstances activities shall not exceed 1:10, Examples would include but not be limited to:

i.Cognitive skills such as researching and recording information, decision making, identifying preferences and values, selecting clothing, interviewing, scheduling appointments, budgeting, personal nutrition planning, etc.;

ii.Physical skills such as showering, grooming, cooking, cleaning personal space, shopping, taking public transportation, parenting, etc.; and

iii.Emotional skills such as negotiating, communicating, asking for help, avoiding risks to sobriety, greeting others, conversing, identifying psychiatric cues, planning for psychiatric emergencies, etc.

5. Prevocational services, which are an array of strategies and interventions that assist in acquiring general work behaviors, attitudes and skills in response to the interests and needs of consumers who are thinking about and/or intending to take on the role of and which may be used in other life domains.

i. Prevocational intervention or strategies selected are based upon an assessment of consumer interest, needs, skills and supports and reflected in the consumer's individual service plan.

ii. Prevocational activities might include, but not be limited to;

(1) Understanding and choosing work settings;
(2) Gathering and researching job information;
(3) Clarifying occupational values and interests;
(4) Defining work preferences;
(5) Identifying personal work criteria;
(6) Exploring barriers to working;
(7) Identifying and defining critical work skills;
(8) Researching personal work supports & resources;

(9) Identifying psychiatric illness management strategies related to working;

(10) Simulated work activities such as work units to address work hardening, concentration, attending and other skills; and

(11) Learning methods to respond to criticism, negotiating for needs, dealing with interpersonal issues, and adherence to medication requirements.

iii. Therapeutic subcontract work may be provided within the context of partial care as prevocational therapy if already provided.

(1) Therapeutic subcontract work activity is the production, assembly and/or packing tasks for compensation obtained by the organization under a contract with a vendor for which individuals with

disabilities performing the tasks are paid under a wage and hour certificate, typically less than minimum wage.

(2) The consumer's individual service plan shall stipulate that the therapeutic subcontract work is a form of intervention intended to address the individual as identified in the consumer's assessment;

(3) The therapeutic subcontract work shall be facilitated by a qualified mental health services worker.

iv. The therapeutic subcontract work activity shall be performed within the line of sight of the qualified mental health service worker;

v. The staff to consumer ratio shall not exceed a ratio of 1:10 qualified mental health services worker to consumer

6. Medication-related services, as needed, which include the following:

i. Medication counseling and education, as defined in N.J.A.C. 10:37-6.53 and 6.54;

ii. Knowledge and documentation of each consumer's current medication treatment/therapies;

iii. Providing a mechanism for staff to share clinical information regarding medication utilization; and

iv. Educating beneficiaries, staff and other caregivers regarding adverse drug reactions, potential side effects and established procedures for responding to crisis situations;

7. Goal-oriented verbal counseling, which may include individual, group and family modalities to address the emotional, cognitive and behavioral symptoms of mental health illness or for engaging, motivating, stabilizing and the related effects on role functioning including consumers with a co-occurring mental health and substance use disorder. Goal oriented verbal counseling may also include motivational interviewing, connecting skills and cognitive behavioral therapy;

8. Age appropriate learning activities which are directly tied to the learning of daily living or other community integration competencies such as financial literacy, learning basic computer literacy, recognition of directions and safety

warnings. Such basic computing, reading or writing skills are considered incidental and not student education;

9. Social/leisure services, which include independent living skills training, interpersonal skills such as greeting, talking about impersonal topics, conversing, learning about available community social and recreational opportunities, planning for leisure time, practicing social interaction, recreational, spiritual and cultural activities; [and]

10. Psychiatric services, which include assessment and ongoing treatment supervision; and

11 Other planning activities may include the development of an advance directive, that meets the requirements of P.L. 2005, c.233 with specific instructions on what steps need to be taken in the event of a relapse and the development of a personal Wellness and Recovery Action Plan (WRAP)

(c) The PA shall develop written descriptions of services, outlines and curricula for activities and interventions directly provided. Clinical records, schedules, rating forms of group and other activities, logs and other documents shall serve as evidence that these services have been provided

(d) Off-site interventions can be provided as long as the consumer is accompanied/supervised by staff and the following conditions are met.

1. The off-site interventions shall be:

i. Individualized for each consumer and non-stigmatizing;

ii. Integrated as a subordinate component of the consumer's IRP, which clearly states each specific off-site intervention and how the intervention relates to the overall achievement of the consumer's specific goals and objectives in the service plan, particularly in assisting to generalize skills to community settings. Services that are solely recreational or diversional in nature shall not be considered a PC activity;

iii. Properly documented in the consumer's record to include when the off-site activity commenced and terminated; and

iv. Limited to a defined and measurable period of time.

2.Off-site services provided weekly shall be generally less than 10 percent of an individual consumer's average active programming time in PC during the previous month. If off-site activities are greater than 10 percent additional

justification is required in the consumer's record and may be subject to program audit by the Division. In no case may the time be more than 20 percent.

3. The consumer must sign in at the site of the partial care program prior to participating in any off-site activity and sign out of the program after completion of the off-site activity.

4. Transportation to and from the off-site activity shall not be counted as partial care program activity time requirement unless the following are met:

    i. The PA has a staff person in the vehicle functioning as a counselor, and there are no more than four consumers in the vehicle. If there are more than four consumers then a second staff person must accompany the counselor and function as a driver; and

    ii. The staff conducts activities during the period of transportation that meet all the requirements for allowable activities of a partial care program.

[2.] (e) The PA shall provide or arrange services based on individual **[**client**]** consumer need. The PA shall participate in service planning, resolve identified issues, and advocate on behalf of the [client**]** consumer, as appropriate, for all

services that are not provided directly. At a minimum, the following services shall be provided or arranged:

[i]. 1. Basic services, which may include assisting **[**clients**]** consumers to procure needed food, clothing, shelter, or income benefits;

[ii.] 2. Health and medical care services, which may include assisting in procurement of, treatment or education about health care and medication;

[iii.] 3**.** Natural support system services, which may include consultation and education with families, friends or landlords, facilitating self-help groups, or helping **[**clients**]** consumers connect with community institutions;

[iv.] 4**.** Financial [services] literacy, which may include money management, saving strategies and budgeting;

[v.] 5. Other prevocational services, which may include sheltered employment, job training, or volunteer work;

6. Other vocational services in community work settings

such as supported employment, transitional employment, [client] consumer owned and operated [business opportunities] entrepreneurial businesses, technical occupational skills training, college preparation, individualized job development and marketing to employers based upon the individual consumer need when the consumer has achieved the prevocational skills listed in his or her IRP or requests such services **[**sheltered employment, supported employment, job training, job placement, or volunteer work**]**;

[vi.] 7. [Client] Consumer-outreach and linkage services designed to facilitate new [clients'] consumers' participation in the program, to re-engage [clients] consumers who have discontinued participating in the program or to effectively link them with other programs that would meet their needs, and to promote continuity of programming for [clients] consumers who are hospitalized during the course of their participation in the program. These services shall include, but are not limited to, arranging needed transportation to the program site, relating to other agencies, and contacting and visiting [clients] consumers who have discontinued participating in the program;

[viii.] 8. Integrated treatment for co-occurring mental health and substance use disorders, which is a distinct clinical approach that combines mental health and addiction into a unified,

comprehensive and blended philosophy that provides prevention, intervention and treatment techniques that simultaneously address the needs from both disorders. Service may include, but is not limited to: a “no wrong door” approach to care, education and life skills management, motivational (staged) treatment, case coordination across systems, dual focus assessment and interventions, milieu of recovery, wellness and empowerment, use of recovery oriented tools and models such as wellness recovery action plan (WRAP),iIllness management recovery (IMR), integration of self help and 12 step into clinical technique;

[vii.] 9. Educational services, which may include basic education courses, special education courses, G.E.D. classes and pre-college preparation to enter community roles identified in the IRP;

[viii. Chemical dependency services, which may include support groups, educational, informational and referral services regarding drugs, alcohol, nicotine and caffeine;]

[ix.] 10. Residential services, which may include assisting consumers to secure community residences, board and care homes, private homes or apartments with support, emergency shelters, cooperative apartments or crisis housing; and

[x.] 11. **[**Acute] Accessing acute care services, which may include screening, crisis intervention and inpatient services.

[3.] (f) The PA shall develop procedures regarding medications to include:

[i.] 1. Identification of each [client's] consumer's medication needs;

[ii.] 2. Documentation of each [client's] consumer's current medications;

[iii.] 3. A mechanism for sharing relevant clinical information with medication providers;

[iv.] 4. Medication education for [clients] consumers and families, where relevant; and

[v.] 5. Provisions for education of staff and other involved caregivers regarding adverse reactions and potential side effects, procedures to respond to such reactions and the [client's] consumer's right to refuse or consent to medication.

[4.] (g) The PA shall develop written descriptions, outlines and curricula for activities and interventions of services directly provided [and] or arranged

for. Clinical records, schedules, logs and other documents shall serve as evidence that these services have been provided.

10:37F-[2. 4]2.6 Termination, transfer and referral of [clients] consumers

(a) Procedures for termination, transfer and referral of [clients] consumers shall be documented and shall ensure that the continuing service needs of [clients] consumers are met.

(b) Discharge criteria shall be identified at the time of admission and shall include the steps necessary to facilitate community integration. The criteria shall be documented in the initial service recommendations and individual recovery plans.

(c) For consumers being transferred to another service, a brief, succinct transition summary shall be prepared at the time of discharge communicating critical information and shall be forwarded to the receiving agency. **[**1. Discharge criteria shall be developed. These**]**

(d) Discharge criteria shall be limited to the following specific reasons for termination from the program:

[i.] 1. The [client] consumer has achieved the service plan goals and needs no further treatment;

[ii.] 2. The [client] consumer can be more effectively served by and has been linked to another program, agency or institution;

[iii.] 3. The [client] consumer has either refused repeatedly to participate in major components of the program or stopped attending the program;

[iv.] 4. The [client] consumer demonstrates dangerous, criminal, or other aggressive behavior that is unresponsive to interventions; or

[v.] 5. The [client] consumer has moved to a location [which] that makes continued participation in the program impossible.

[2.] (e) When the [client] consumer has stopped attending the program, significant outreach efforts to re-engage the **[**client**]** consumer prior to termination, such as repeated telephone calls, correspondence and home visits shall be documented in the clinical record.

[3] (f) Termination decisions shall be finalized only with approval of the direct care staff supervisor.

[4.] (g) Every effort shall be made to consider the [client's] consumer's preferences for continuing services and to include the [client] consumer in the development of the discharge plan.

[5.] (h) The discharge plan shall include arranged follow-up care or justification for no follow-up care.

[6.] (i) A termination or transfer summary shall be written and maintained, separate from the progress notes. The summary shall be completed within 30 days of termination or transfer and shall include:

[i.] 1. The presenting problem;

[ii.] 2. The admission date and date of service termination;

[iii.] 3. The course of treatment and [client's] consumer's status upon discharge;

[iv.] 4. The reason for termination;

[v.] 5. The medication prescribed upon discharge;

[vi.] 6. To the extent known, the [client's] consumer's perspective on his or her experience in the program, and the [client's] consumer's stated reasons for leaving, if applicable; and

[vii.] 7. The discharge plan.

10:37F-[2.5]2.7 Management functions

(a) In addition to meeting the management requirements as promulgated in N.J.A.C. 10:37D, the PA shall also perform the following management functions:

1. Data on [client] consumer characteristics, such as diagnosis, cultural and communication issues and service needs in addition to [Partial Care] partial care; program utilization; and outcomes shall be collected, analyzed and used for program design;

2. [Client] Consumer input from [client] consumer surveys, exit interviews and other mechanisms shall be utilized by management;

3. Structured and informal opportunities for [client] consumer input and

participation, such as [client] consumer management, organization or town meetings, shall be provided;

4. Staff input regarding program design, development, or changes shall be solicited through supervisory meetings, team meetings, and other mechanisms utilized by management;

5. Staff and [client] consumer involvement and participation in larger "systems-oriented" activities, such as conferences, seminars, workshops, or membership in local, State, or national organizations shall be encouraged whenever possible;

6. The PA shall conduct regularly scheduled meetings for staff and [clients] consumers to discuss program issues; and

7. The PA shall develop written policies and procedures regarding the release of confidential [client] consumer information within the program and among other [clients] consumers and staff. These policies and procedures shall comply with all related Federal and State statutes and any Department rules.

10:37F-[2.6]2.8 Quality assurance activities

(a) In addition to meeting the quality assurance requirements as promulgated in N.J.A.C. 10:37-9, the PA shall address the following areas:

1. [Client] Consumer outcome measures shall be monitored based on [client] consumer-identified and program-identified goals; and

2. [Client] Consumer satisfaction and family satisfaction, and efforts to engage [clients] consumers, shall be monitored.

10:37F-[2.7]2.9 Therapeutic environment

(a) The PA shall provide a safe environment, normalized to the extent possible, that shall serve to enhance interaction among staff and [clients] consumers.

1. The PA shall conform to all Federal, State and local laws and shall provide evidence of satisfactory inspections.

2. The PA shall document that monitoring and follow-up on all safety and health issues identified by inspections or by the PA has occurred.

3. The PA shall document evidence of regular cleaning and maintenance of the facility.

4. Staff trained in CPR and first aid shall be available during program operation.

5. The PA shall have procedures for responding to emergency situations, including assaultive and suicidal behavior and ideation, acute decompensation, and medical emergencies.

10:37F-[2.8]2.10 Staffing

(a) The PA shall be sufficiently staffed with [qualified] personnel, who are licensed, when required, appropriately credentialed, culturally competent and sufficiently trained to provide PC services as set forth in this chapter. Staff may be engaged on a full time, part time or consulting basis, provided that services are adequate to meet the program needs of participating [clients] consumers.

(b) The PA shall, at a minimum, employ the following staff titles with the following responsibilities:

1. The program director shall:

i. Have primary responsibility for program operation, development and management;

ii. Be available for crisis consultation and management and for coordination with outside practitioners; and

iii. Possess a master's degree in a human service field and five years experience in mental health services, with two years supervisory experience or possess a professional credential such as: licensed clinical social worker, licensed professional counselor, licensed rehabilitation counselor, licensed clinical alcohol and drug counselor, licensed psychologist, advanced practice nurse or master of science in nursing with the requisite number of years of experience;

2. The medical director or supervising psychiatrist shall:

i. Be a physician licensed to practice in the State of New Jersey and board [eligible or] certified or eligible in general psychiatry;

ii. Provide needed medical input into the development of the program;

iii. Be directly affiliated with the program;

iv. Assume professional responsibility for the treatment and services provided and assure that the treatment and services are medically appropriate;

v. Supervise the treatment provided to each [client] consumer;

vi. Provide input into treatment and service plans;

vii. Provide initial psychiatric assessment and ongoing psychiatric review at least two times per year;

viii. Provide consultation to program staff on an ongoing basis;

ix. Be available and provide in-service training to program staff; and

x. Assure that all psychiatric and medical services that are provided by the program, meet accepted standards of medical practice.

3. The direct care on-site staff supervisor shall:

i. Have primary responsibility for supervision of direct care staff; and

ii. Possess a master's degree in a mental health, rehabilitation or human services field, or a bachelor's degree and a minimum of two years experience in providing mental health services or possess a relevant professional credential such as: licensed clinical social worker, licensed professional counselor, licensed rehabilitation counselor, licensed clinical alcohol and drug counselor, licensed psychologist or master of science in nursing

4. The primary case coordinator or counselor shall:

i. Have primary responsibility for service coordination, provision or arrangement of services needed, personal advocacy, and development, review and updating of individual treatment and service plans; and

ii. Possess a bachelor's degree in a human services field, or an associate's degree and two years experience in providing human services, or five years of human service experience, or possess a relevant professional credential such as certified psychiatric rehabilitation practitioner, licensed associate counselor, bachelor in social work, certified rehabilitation counselor, certified alcohol and

drug counselor, bachelor in rehabilitation, bachelor of science in nursing

5. The mental health services worker shall:

i. Have primary responsibility for the provision and coordination of program services; and

ii. Possess a Bachelor's degree or Associate's degree in psychosocial rehabilitation or mental health services; or possess related life or work experience, such as assuming leadership roles during participation in mental health services or mental health consumer initiatives; or possess one of the following credentials: certified psychiatric rehabilitation practitioner, community mental health associate

(c) Each PA shall designate staff to take primary responsibility for providing pre-vocational and [chemical dependency] integrated treatment for co-occurring mental health and substance use disorders services. Such designated staff members shall possess the qualifications for the primary case coordinator or counselor position and shall have training and experience in providing the specialized service.

1. Qualifications for the primary staff providing pre-vocational services must include one year's experience in providing services such as supported employment or job coaching, vocational evaluation, welfare to work, community rehabilitation services, transitional employment, other work experience programs for consumers and recent relevant training or possess one of the following: certified rehabilitation counselor, licensed rehabilitation counselor, masters or bachelor's in rehabilitation counseling, certified psychiatric rehabilitation practitioner, vocational instructor as defined by the New Jersey State Board of Education.

    i. Qualified staff shall maintain their knowledge and expertise by continuing to receive recent, relevant training and continuing education.

2. Qualifications for the primary staff providing integrated treatment for co-occurring mental health and substance use disorder services must follow the requirements as set forth by the Alcohol and Drug Counselor Committee of the State Board of Marriage and Family Therapy Examiners

(d) The PA may employ students and volunteers, in addition to required staff as

set forth in this chapter.

(e) The PA shall make continuing education available in order to ensure that staff has the competencies necessary to deliver the core program areas.